REPORT FORM FOR CHANGE IN MENTAL STATUS

PATIENT NAME:_____ DATE OF BIRTH:_____
ADDDRESS:_____
SOCIAL SECURITY#:_____
TENNCARE/MEDICAID #_____

PROVIDER:_____
ADDRESS:_____ TELEPHONE:_____
FAX NO.:_____

YES NO (Please check yes or no.)

( ) ( ) Has the individual had any previous evidence of mental illness?

( ) ( ) Are there any current signs or symptoms ofmental illness? If yes, complete items below:
_____affect changes _____ hallucinations _____other_____
_____delusions _____ mood changes _____depression, profound
_____ problems with orientation

( ) ( ) Are any of these symptoms more pronounced than typical for this individual?
_____

( ) ( ) List any current and/or past psychiatric diagnoses.

_____
_____
_____

( ) ( ) Has the patient experienced any significant changes in behavior? If yes, describe the behavior, including its onset and duration.

_____
_____
_____
_____

( ) ( ) Is the patient a danger to self or others? ( ) self ( ) others ( ) both

( ) ( ) Have there been any recent changes in the patient's medications? If yes, please describe the changes including dates of initiation or discontinuing therapy, and identify, if possible, any relationship in changes to behavior.

_____
_____
_____
_____

( ) ( ) Has the patient recently experienced a sudden increase or decrease in weight? If yes, indicate the amount of weight change, the time period involved and most likely reason for the change.
_____
_____

( ) ( ) Has the patient had any significant changes in physical functioning or medical status? If yes, describe the changes, including onset and duration.
_____
_____
_____

( ) ( ) Has there been a neurological and/pr history and physical evaluation performed within the past 6 to 12 months by a physician to rule out an organic or medical cause for this change in mental status? If yes, please submit this form.

Additional information such as physician notes or nursing notes that describe the behavior may be included. You should also include any consultations or evaluations that are pertinent to the behavior changes.

Signature of RN or Social Worker completing:

_____ Date:_____